STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS)
DETERMINED BY DIRIGO)
HEALTH FOR THE THIRD)
ASSESSMENT YEAR)

FILING COVER SHEET

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Attn: Vanessa J. Leon, Docket No. INS-07-900
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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE THIRD ASSESSMENT YEAR	)	BRIEF OF THE MAINE AUTOMOBILE DEALERS ASSOCIATION INSURANCE TRUST
DOCKET NO. INS-07-900	)	

NOW COMES the Intervenor, Maine Automobile Dealers Association Insurance Trust (the "Trust"), by and through its undersigned counsel, and, pursuant to pursuant to the Acting Superintendent's Notice of Pending Proceeding and Hearing dated July 19, 2007, and his Order on Intervention and Procedures dated August 7, 2007, submits the following brief.

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INTRODUCTION

Once again the parties are before the Superintendent as part of their annual journey through the *Twilight Zone* that is the Dirigo Health Agency Board of Directors' ("DHA Board") determination of aggregate measurable cost savings ("AMCS"). This year, the DHA Board has presented the Superintendent with an AMCS figure that is a shade over the AMCS figures approved by the Superintendent for the prior two assessment years *combined*. Indeed, without blushing, the DHA Board claims to have found a 228% year-over-year increase in AMCS as the result of a program that has not increased appreciably in size, in a market where the cost growth trend has been flat,[1] and while purportedly following the Superintendent's guidance from prior years. Of course, the DHA Board was able to reach this conclusion only after conducting a proceeding that had all of the fairness of a Cuban election, and adopting a methodology that even the Dirigo Health Agency's ("DHA") own consultant, Schramm-Raleigh Health Strategy, ("SRHS"), doubted would fly.[2]

[1] (Administrative Record "AR" at 342-43, 6755, 6956).

[2] Two documents produced by the DHA suggest that there was a meeting on May 9, 2007, in which personnel at SRHS anticipated proposing $100 million in AMCS savings, that the DHA Board would make an AMCS determination of approximately $40 million on July 25, and that the Superintendent would later reduce that figure to around $30 million. (AR at 6984, 7022). If DHA and its consultants do not believe the AMCS figure, why should anyone else?

On several occasions, the DHA Board professed that it was looking forward to further guidance from the Superintendent. In fact, its Chairman remarked that the Superintendent gets another "shot at this" and referred to the "checks and balances" contemplated in the statute. (AR at 477). As demonstrated in the proceedings for the past two assessment years, the Superintendent has an active role to play in this process and is to make an independent assessment of the DHA Board's filing based on the record. The Trust asks only that the Superintendent give the DHA Board what it claims to want and desperately needs -- his informed guidance.

ARGUMENT

To avoid undue repetition, the Trust adopts the arguments set forth in the brief filed by the Maine State Chamber of Commerce ("Chamber") and will not repeat them here.

I. The DHA Board's AMCS Determination Is Constitutionally Infirm.

The DHA Board's AMCS determination is constitutionally infirm in two respects: (1) the proceedings before the DHA Board did not comport with Due Process; and (2) 24-A M.R.S.A. § 6913(1)(A) represents an unconstitutional delegation of legislative authority. A discussion of each of these constitutional infirmities is set forth in turn below.

A. The Proceedings Before The DHA Board Did Not Comport With Even The Most Basic Requirements Of Due Process.

As the Law Court has noted, "The essential requirement of due process in the administrative context is that a party be given notice and an opportunity to be heard." Maddocks v. Unemployment Ins. Comm'n, 2001 ME 60, ¶ 7, 768 A.2d 1023, 1025. The conduct of the proceeding before the DHA Board, however, fell well short of that standard.

In February, the Legislature changed the deadline for the DHA Board's annual AMCS determination from April 1 to August 1. See P.L. 2007, ch. 1, Part X, § 1 (effective Feb. 13,

2007). SRHS began to pull together the information on which its proposed AMCS methodology would be based by early February, in anticipation of what was until February 13, 2007 an April 1st deadline, and entered into its contract with the DHA on March 22, 2007. (AR at 103, 106-108, 6924-32). By early May, the DHA was contemplating hearing dates in mid-July and having a final report from SRHS by June 10. (AR at 6969, 6984, 7022).

The DHA Board, however, did not issue its Notice of Pending Proceeding and Hearing until June 14, 2007. (AR at 629-30). The DHA Board set hearing dates of July 23 and 24, and in its Procedural Order No. 1 originally contemplated that the DHA's proposed AMCS methodology and supporting data would be made available to the intervenors a mere four days prior to the start of the hearing and three days *after* the intervenors designated their witnesses. (AR at 631-34).[3]

The Trust, the Chamber, and the Maine Association of Health Plans were not granted intervenor status until July 2, 2007,[4] and the DHA's proposed methodology was provided to them on the afternoon of July 3. (AR at 79, 635). The proposed methodology was set forth in a 56-page report recommended an AMCS determination of $92.7 million. (AR at 5245-5300). Notwithstanding the DHA Board's assertion that the "methodologies for the most part ha[d] not changed significantly," (AR at 4 n.1), as discussed more fully below, the CMAD methodology was tweaked in several respects (including abandoning the Superintendent's approved use of the median in favor of the mean), and the uninsured/underinsured savings methodology that had been used in the two prior assessment years was jettisoned in favor of a "new money in the

[3] It should come as no surprise that the DHA Board, which was capable of crafting such an extraordinary order, would, without blinking an eye, find the process it created to be reasonable.

[4] The seven-day period for responding to applications for intervention was actually the longest response period set forth in Procedural Order No. 1. (AR at 631-34). Of course, for the prior two assessment years not one intervention application had been opposed, let alone denied.

system" approach. The Trust and its fellow intervenors, therefore, had a mere three weeks in which to prepare their case in response to a $92.7 million AMCS proposal based on a methodology differing from that used in years past.

The shortness of this time frame was exacerbated by the DHA's late production of the documents and data supporting its proposed methodology. The DHA did not make available those documents, consisting of over 3,500 pages, until the afternoon of Friday, July 13, 2007 (AR at 79, 488) – three days before the parties were required to exchange witness lists and documents; six days before the deadline for filing pre-filed testimony and exhibits; and ten days prior to the start of the hearing. Of course, by that time it was too late for the intervenors to (1) issue any follow-up information requests (unless, of course, they were content to receive a response *after* the conclusion of the hearing); or (2) request the issuance of a subpoena. See Code of Maine Rules 96-629-4, § 10(B)(4) (providing 14 days in which to respond to information requests) and § 12(D) (requests for subpoenas must be made no later than 10 days prior to the hearing date).

The fact that the DHA was filing amended pre-filing testimony right up until the close of business on the last business day prior to the start of the hearing certainly did not help matters. As has become par for the course, the DHA's consultant made a basic error in its original report, which threw its proposed CMAD savings off by $4 million. (AR at 5357-58). It is remarkable that the DHA Board is able to sit back and watch the DHA unabashedly make eleventh hour revisions to the proposed AMCS calculation its consultants had been working on for several months, while intoning that the intervenors had enough time to prepare. One has to wonder what other errors the intervenors could have brought to light had they been able to operate under a less draconian schedule.[5]

[5] Recall that in the Year 1 proceeding before the Superintendent the intervenors had about twice the amount of time in which to prepare and the Chamber's counsel was able to demonstrate $26 million

Further casting doubt on the fairness of the proceedings is the fact that DHA's contract contemplated that SRHS would "strategize" with stakeholders in developing its methodology. (AR at 6927). SRHS's "strategizing," however, was limited to consulting with Consumers for Affordable Health Care ("CAHC") and its counsel to the exclusion of all of the other intervenors. (AR at 426). In fact, the "strategizing" went so far as Mr. Schramm assisting CAHC's counsel in preparing his cross-examination of him. (AR at 426). A process in which one intervenor is consulted in the development of the proposed AMCS methodology, while the other intervenors get their first peek three weeks before the hearing, is fundamentally unfair.

During its deliberations, the DHA Board's chairman noted the following:

> Let me also raise before you, because this is the time, I want to make sure the record indicates the board has heard the concerns about the fairness of the hearing itself including the short time to prepare, the delayed grant of intervener status, the delayed production of documentation and the very compressed time frame that we found ourselves in *despite the fact that we had the data earlier than any other preceding years*. I, for one, certainly would hope that we would extend this process into a more workable time frame in the future if this is repeated so that it, out of the degree of fairness, it could be in a more deliberate fashion.

(AR at 565). While a fairly succinct synopsis of the problem, the Trust takes issue with the suggestion that the DHA was also a victim of the compressed time period. The fact remains that the DHA Board was aware of the statutory deadline, and it was exclusively within its power to schedule the hearing in this manner to provide all involved a reasonable opportunity to prepare their cases.

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worth of computational errors in the first few moments of his cross-examination of the DHA's consultant, Dr. Nancy Kane.

B. The Ever-Changing AMCS Methodologies Approved By The DHA Board Conclusively Establishes That 24-A M.R.S.A. § 6913(1)(A) Is An Unconstitutional Delegation Of Legislative Authority.

Once again, the DHA Board was tasked with making an AMCS determination in accordance with the following statutory language:

> [T]he [Dirigo] Board shall determine annually … the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this state as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. § 6913(1)(A).

Recently, in the context of the appeal from the Year 1 AMCS determination, the Law Court found this statutory language to be ambiguous. See Maine Ass'n of Health Plans v. Superintendent of Insurance, 2007 ME 69, ¶¶ 37, 41, 62, 72, 923 A.2d 918, 928, 929, 935, 937 (hereinafter "MEAHP v. Superintendent"). Although the Law Court simply deferred to the Board's interpretation, Justice Alexander, in dissent, recognized that the statute's abject lack of quantitative standards to guide the Board in determining AMCS constituted an unconstitutional delegation of legislative authority:

> When terminology in a statute is so vague and ambiguous that those regulated must guess at its meaning, and an agency is given license to act based on preferences or criteria so subjective that they are virtually unreviewable, we have held that such subjective license is an improper delegation of legislative authority to the executive.

Id., 2007 ME 69, ¶ 71, 923 A.2d at 936 (citing Kosalka v. Town of Georgetown, 2000 ME 106, ¶ 17, 752 A.2d 183, 187)). Indeed, Justice Alexander warned that merely deferring "giv[es] the agency license to assess offset payments according to whatever definition of 'cost savings' the agency deems appropriate to meet its financial needs."[6] Id., 2007 ME 69, ¶ 63, 923 A.2d at 935.

[6] The Law Court expressly did not address this issue. See MEAHP v. Superintendent, 2007 ME 69, ¶ 58 n.14, 923 A.2d at 934 n.14.

Justice Alexander's warning has been borne out by history. Each year, the AMCS methodology offered up by the DHA and its consultants changes. For example, the Year 1 methodology recently affirmed by the Law Court included purported savings attributable to adherence to voluntary CMAD targets because they were contained in P.L. 2003, ch. 469, § F-1(1)(B). For Year 2, however, the methodology included savings attributed to CMAD despite the fact that the statutory reference on which the DHA hung its hat a year earlier had been repealed – the justification offered up by the DHA Board and approved by the Board was that CMAD was properly includable in AMCS because of a Maine Hospital Association press release. (AR at 2790-91). For Year 3, voluntary CMAD targets have returned statutorily, see P.L. 2005, ch. 394, § 4, and savings attributed to CMAD are included in the methodology on that basis. (AR at 5310, 5410).

The methodology adopted by DHA Board for Year 3 represents a complete overhaul in the manner by which savings attributed to uninsured/under-insured savings initiatives are calculated. For Years 1 and 2, savings for uninsured/under-insured initiatives were calculated by measuring changes in hospital Bad Debt and Charity Care; for Year 3, those savings were calculated by estimating the amount of new money in the health care system from those previously uninsured and under-insured who are now enrolled in either DirigoChoice of the Maine Care Parents Expansion ("new money in the system"). (AR at 5315, 5329, 5410, 5422-23, 6590). Remarkably, the genesis of the "new money" methodology is a position set forth in a (1) *draft* report (2) spawned by a working group having, at best, an uncertain future (3) that reached no consensus, and (4) was convened by the Board on the recommendation of a Blue Ribbon Commission created by Executive Order three-years after the passage of the statute to which the Dirigo Health program owes its existence, and which was tasked with exploring potential

alternatives to the current funding mechanism of which the Board's AMCS determination is but the first step. (AR at 92, 3086-95, 5315, 5423, 5429-30, 6867-69, 6885-89). That, however, is hardly a credible source for a new uninsured/under-insured savings methodology to replace the methodology used during the two previous assessment years, the propriety of which was affirmed by the Law Court a month prior to the issuance of SRHS's Report.

As was the case in the Year 2 proceeding, SRHS stated *ad nauseum* that it adhered to "guidance" (sometimes referred to as "direction" or "feedback") from the Superintendent of Insurance's (the "Superintendent") reviews of the AMCS methodologies adopted by the Board in Years 1 and 2. However, it is clear that SRHS equates "guidance" with "suggestions" and cherry picks only that "guidance" from the Superintendent that it chooses to follow. Most glaringly, SRHS has eschewed the use of the median percentage increase in hospital cost growth in calculating CMAD, choosing instead to rely on the mean percentage increase in hospital cost growth. (AR at 5312, 5313, 5325-26). According to SRHS, the mean is a "better measure" than the median. However, that very argument was expressly rejected in the Year 2 proceeding when the DHA Board itself found the use of the median as advocated by the Intervenors to be more appropriate than the mean in measuring CMAD savings.[7] (AR at 2751-52, 2764-73, 2792). The Superintendent then affirmed the Board's selection of the median over the mean. (AR at 2981-83). The reason for SRHS's persistence, in the face of the DHA Board's Year 2 AMCS determination, in advocating the use of the mean is clear -- it produces a larger CMAD figure for its client than the median does.

[7] SRHS contends that the DHA Board approved the use of the median as a way of accounting for a variety of variables and that it had already accounted for those variables with other modifications to its CMAD methodology. (AR at 5325-26, 5420). A review of its Decision and the transcripts of its deliberations, however, makes clear that the DHA Board chose the median to account for the anomalously high growth rate in 2002. (AR at 2751-52, 2764-73, 2792).

In short, the AMCS methodology approved by the DHA Board conclusively validates Justice Alexander's warning that Section 6913(1)(A) is so devoid of criteria to guide the determination of AMCS, that AMCS has come to mean whatever the DHA says it means at any particular moment in time.

II. The Under-Insured Savings Have No Reasonable Basis.

As noted above, the "new money to the system" approach adopted by the DHA Board identifies as "savings" so-called "new money" in the health care system attributable to previously uninsured and underinsured DirigoChoice enrollees. Although the DHA Board ultimately adopted the methodology used by Mr. Burke (AR at 8, 595-98), Mr. Burke's methodology used SRHS's definition of under-insured and the under-insured percentage calculated by SRHS. (AR at 6778, 6789). Although Mr. Burke's methodology is preferable to the one advanced by SRHS, its reliance on the flawed work of SRHS renders its use unreasonable.

A. The Definition Of Under-Insured Has No Basis In Reality.

In determining the number of DirigoChoice enrollees who were previously under-insured, SRHS considered to be under-insured those DirigoChoice enrollees who whose household income is less than 200% of the Federal Poverty Level and whose deductible for their prior coverage exceeded 5% of household income.[8] (AR at 4858) See Report at Appendix I. This definition ignores two key variables – premium, and level of coverage.[9]

[8] At no point did SRHS provide any kind of support for the twin notions that one's status as under-insured can be determined simply by examining the ratio of one's deductible to household income and that 5% is the appropriate ratio to be used.

[9] Mr. Burke attempts to account for these variables by means of an induced utilization adjustment. (AR at 452, 454, 457, 6780). The Trust, however, submits that the consideration of these variables must be considered in determining who is under-insured in the first instance, rather than simply when determining the impact of those already found to be under-insured.

1. Premium.

There is an inverse correlation between deductible and premium; in other words, as premiums decrease, deductibles generally increase. That is true for the DirigoChoice product itself. (AR at 6976). By focusing exclusively on the deductible side of the equation, SRHS ignores the fact that similarly situated people may make different decisions regarding what they are willing to pay in terms of a monthly premium and what they will accept for a deductible. The absurdity of allowing the determination of savings attributable to under-insureds to turn on the vagaries of personal preference at the time of enrollment is laid bare by the following hypothetical:

> A and B are employees of the same company, which provides health insurance coverage to them from insurance company X. A and B have families of four, have identical household incomes of $30,000,[10] and have identical coverage. A, however, has an annual family deductible of $1,400 (4.66% of household income), while B has a family deductible of $1,600 (5.33% of household income), but pays a lower monthly premium than A.

Under the SRHS methodology, B is underinsured, while A is not simply because B offset lower monthly premium payments with a $200 higher deductible.

2. Level Of Coverage.

A DirigoChoice enrollee may have had a higher level of coverage under his prior policy than he currently has with DirigoChoice. An inferior insurance product with a lower deductible may leave one with less protection against a catastrophic claim than a superior insurance product with a higher deductible; the converse could also be true.

Moreover, since the DirigoChoice provider network is coextensive with Anthem's, it does not include every physician in the state. (AR at 191, 442). The DirigoChoice plans cover 80% of in-network costs, but only 50% of out-of-network costs. (AR at 6977-83). On cross-

[10] $30,000 is 150% of the Federal Poverty Level for a four-person household. (AR at 6205).

examination, Mr. Schramm acknowledged that a DirigoChoice enrollee who made the choice to stay with a provider who is outside the DirigoChoice network, but who was within the prior insurer's network, would, under DirigoChoice, have a lower effective level of coverage than he had before. (AR at 442-43).

As was the case above, a hypothetical lays bare the importance of this variable that SRHS failed to consider:

> B from the example above has now seen the light and enrolled in DirigoChoice Plan 1. Let's assume that his prior coverage with insurance company X was under a policy that provided an 80% in-network benefit, and that his doctor, Doctor Z, is a member of X's provider network, but not DirigoChoice's. Doctor Z performs a procedure costing $3,000 and B has fully met his $1,000 annual deductible.

Under his prior coverage B would be looking at a bill of $600, but under his current coverage, he is looking at a bill of $1,500: yet somehow in SRHS's distorted world view, B was underinsured when he was with X, but is not underinsured now that he is with DirigoChoice (since his deductible is only 3.33% of household income).[11]

B. <u>It Is Disingenuous For The DHA Board To Claim That New Money Attributable To Previously Under-Insured DirigoChoice Enrollees Constitutes Savings When There Are DirigoChoice Enrollees Who Meet SRHS's Definition Of "Under-Insured".</u>

On cross-examination, Mr. Schramm acknowledged that "[t]here are individuals on DirigoChoice that could qualify for the definition of underinsured." (AR at 435). He further admitted that he has no idea how many DirigoChoice enrollees are under-insured, nor did he attempt to find that out. (AR at 435, 436-37). Remarkably, SRHS claims that new money allegedly flowing into the system as a result of previously under-insured persons migrating to

[11] Lest the Trust be accused of hypocrisy for not accounting for B's lower deductible under DirigoChoice, B is still out-of-pocket more money under DirigoChoice ($2,500), than he would have been had he stayed with X ($2,200).

DirigoChoice represents savings in AMCS, despite the fact that it cannot quantify the number of under-insureds DirigoChoice is itself producing.

In apparent recognition of this incongruity, Mr. Schramm testified that SRHS accounted for the under-insured population within DirigoChoice by using $3,761 as the size of the average claim paid for the previously under-insured Dirigo enrollees. (AR at 437, 5349). It should come as no surprise to anyone having the slightest familiarity with these proceedings over the past few years that Mr. Schramm stated that the $3,761 figure was a "conservative assumption," based on the fact that Dr. Kenneth Thorpe had informed him that the actual average claim paid figure was some unspecified lower amount. (AR at 437-38). As the following colloquy makes clear, however, the $3,761 figure itself has no empirical support:

> Q. You picked out a number you thought was okay and you plugged it in?
>
> A. Yes.
>
> Q. You don't have any data, map [sic], or analysis to back it up other than Dr. Thorpe's concern that you address the issue?
>
> A. Correct.

(AR at 438).

In other words, Mr. Schramm claims that despite the fact that he has absolutely no idea of its size, he accounted for the under-insured population within DirigoChoice by using a paid claims figure having no analytical support that is larger than the unspecified actual figure.

C. <u>The Manner By Which SRHS Determined The Percentage Of Previously Under-Insured DirigoChoice Enrollees Was Unreasonable.</u>

SRHS concluded that 25.79% of the total DirigoChoice enrollment was previously under-insured. (AR at 441, 6168). It arrived at that percentage as follows:

1. The 8,810 members who enrolled in DirigoChoice after 2005 participated in a telephone survey;

2. Of the 8,810 members interviewed, 5,929 indicated that they had been insured prior to enrolling in DirigoChoice;

3. Of those 5,929 members, 3,012 answered the question of what their deductible had been under their prior coverage;

4. Of those 3,012 members who answered the question, 1,882 (62.5%) met SRHS's definition of under-insured;

5. SRHS then extrapolated the 62.5% to the entire survey population indicating prior coverage (5,929 x 0.625) to arrive a total number of under-insured, 3,705; and

6. Divided the total number of under-insured by the total population (3,705 / 14,367) to arrive at 25.79%.

(AR at 438-41, 6168).

SRHS, however, knows nothing about the non-responders other than the fact that they did not respond to the question. (AR at 440). Without knowing more about those who did not respond and the manner in which the survey was conducted, it is unreasonable to simply assume that since 62.5% of the 3,012 enrollees who responded to the deductible question indicated they were previously under-insured, 62.5% of the 2,917 enrollees who did not respond must also have been previously under-insured. This is simply another self-serving assumption designed to boost the DHA's proposed AMCS figure. At *best*, SRHS managed to show only that 1,882 DirigoChoice enrollees (13.1%) were previously under-insured and any savings attributed to the previously under-insured should be correspondingly limited.

CONCLUSION

For all of the foregoing reasons, the Superintendent should disapprove the Board's filing in its entirety.

Dated: August 21, 2007

Respectfully submitted,

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